

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 04/19/2011	
NAME OF PROVIDER OR SUPPLIER BLISS HOUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 3008 SHAWNEE DRIVE SOUTH BEDFORD, IN47421			
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R0000	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: April 18 and 19, 2011</p> <p>Facility Number: 004011 Provider Number: 004011 AIM Number: n/a</p> <p>Survey team: Melinda Lewis, RN, TC Marla Potts, RN,</p> <p>Census bed type: Residential: 37 Total: 37</p> <p>Census payor type: Other: 37 Total: 37</p> <p>Sample: 8</p> <p>These State findings are cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 21, 2011 by Bev Faulkner, RN</p>			R0000	<p>Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited and is also not to be construed as an admission against interest by the residence, or any employees, agents or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/24/2011

FORM APPROVED

OMB NO. 0938-0391

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R0117	<p>(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions.</p> <p>Based on interview and record review, the facility failed to ensure the facility is staffed with an employee trained in first aid 24 hours per day for 10 of 10 days reviewed.</p> <p>Findings include:</p> <p>On 4/19/11 at 11:00 A.M., the review of the employee records indicated only 2 of the 17 employees had first aid training, the Activity Director and one CNA.</p>		R0117	<p>R117420LAC 16.2-5-1-4(b)PersonnnelWhat corrective actions(s) will be accomplished for those residents found to have been affected by this deficient practice?No residents were found to be affected.How facility will identify other resident have potential to be affected by the same deficient practice and what corrective action will be taken?No Other residents were found to be affected.What measureres will be put into place or what systemic changes will the facility make to ensure that the deficient practice</p>		05/31/2011	

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	<p>In an interview with the Residence Director, on 4/19/11 at 10:30 A.M., she indicated the Activity Director work schedule varied, and was not scheduled as she came in according to the activities.</p> <p>The nursing schedule was provided by the Wellness Director, on 4/18/11 at 1:15 P.M. The review of the schedule for 4/10 through 4/19/11 indicated the facility had 8 hours when a staff member was trained in first aid on duty on the following dates: 4/10, 4/12, 4/13, 4/15, and 4/18/11. The remainder of the nursing schedule there was no one trained in first aid on duty.</p>		<p>does not recur? The Wellness Director and Residence Director were re-educated to our policy and procedure and state ruling 420LACI6.2-5-1-4(b) Personnel regarding CPR and First Aid. The Residence Director scheduled a CPR/First Aid class from an accredited instructor for current staff to ensure Bliss House has a minimum of one(1) awake staff member on duty at all times with current CPR/First Aid Certification at all times. How will the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and/or Designee will complete a random monthly review of current employee records for a period of six months to ensure we have scheduled one(1) awake staff member with current CPR/first Aid certification in our community at all times. findings will be reviewed and corrected through the QA process. The interdisciplinary team will review findings after three months to evaluate the need for ongoing monitoring. Completion date: May 31, 2011</p>		

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R0214	<p>(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.</p> <p>Based on interview and record review, the facility failed to ensure an evaluation was made of the individual needs of each resident prior to admission and at least semiannually for 3 of 7 residents reviewed for assessments, in the sample of 8.</p> <p>Resident #6, #5, #3</p> <p>Findings include:</p> <p>1. Resident # 6's clinical record was reviewed on 4/18/11 at 11:00 A.M. The billing date was 3/12/10 and the move date 5/21/10. The most recent service</p>			R0214	<p>Citation #2R214410IAC16.2-5-2 (a)EvaluationWhat corrective action will be accomplished for the residents found to have been affected by this deficient practice?No residents were found to be affected. Resident#3,#5, and #6 had their Service Level Assessment and Negotiated Service Plan updated to reflect the resident's current medical condition,scheduled/unscheduled needs, and interventions to be performed by staff in effort to minimize the risk for falls and behavioral disturbances. Resident#3,#5, and #6 also had their nursing assessments updated to reflect the resident's</p>		05/31/2011

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	<p>assessment/negotiated service plan, was dated 3/12/10. The service plan indicated the facility administered the resident's medications, the resident had not fallen and no interventions were listed. The resident had difficulty recalling the day, date, time and where located, she did not wander or attempt to leave the facility, with no interventions listed on the service plan for those behaviors.</p> <p>Resident service notes indicated the resident attempted to exit the facility on 12/2/10 at 2 p.m., through the back door, was very upset, and returned to facility by staff members. On 12/10/10 at "7 P resident noted wandering exit seeking, has become agitated combative with staff and other residents...threw a ceramic vase at nurse..." On 12/11/10, the resident was admitted to the hospital and returned 12/13/11. Nurse notes indicated increased agitation on 2/4/11 9 p.m. "attempting to open other residents doors going into rooms when able, took items from others rooms, unable to redirect...." "2/6/11 9 PM res increased agitation exit seeking attempting to exit building and enter others rooms...one on one most of shift..." "2/8/11 10 15 no a.m. or p.m. Resident found on floor in apt lying supine..."</p> <p>During an interview on 4/19/11 at 9:30</p>		<p>current medical status per the Wellness Director's Assessment. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? The Residence Director, Wellness Director and/or Designee will review current resident files to confirm that the Service Level Assessment and Negotiated Service Plans are in compliance. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Residence Director and Wellness Director were re-educated to our policy and procedure regarding our Nursing assessments/Evaluations and our Service Level Assessment and Negotiated Service plans. Resident Service Plans will be updated prior to admission, semi annually and with a change of condition. The Residents Service Level Assessment will reflect the resident's scheduled and unscheduled needs as well as current medical condition. Resident assessments will be updated with interventions in effort to minimize the risk for falls and behavioral disturbances. Resident's Nursing assessments are to be completed per our policy within initial admittance and on an ongoing basis as defined within our Resource manual. A</p>		

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	<p>a.m., the Health Facility Administrator indicated she had no other service assessment/negotiated service plan for this resident.</p> <p>2. Resident #5's clinical record was reviewed on 4/18/11 at 9:30 a.m. The most recent service assessment/negotiated service plan was dated 9/12/10. During an interview on 4/19/11 at 9:30 a.m., the Health Facility Administrator indicated she had no other service assessment/negotiated service plan for this resident.</p> <p>3. The clinical record for Resident # 3 was reviewed on 4/18/11 at 11:00 A.M. The record indicated Resident # 3 had diagnoses that included but were not limited to congestive heart failure and history of anxiety. The record indicated Resident # 3 was admitted to the facility on 2/14/11. The record lacked documentation of a Preadmission Assessment being completed.</p> <p>In an interview with the Wellness</p>		<p>spread sheet was developed and implemented in effort to ensure continued compliance with our nursing Assessments/Evaluations as indicated within our policy and procedure. How will the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Residence Director and Wellness Director will review current Service Level Assessments and Nursing assessments/Evaluations no less than semi annually on an ongoing basis in order to ensure continued compliance with Indiana State ruling 410IAC 16.2-5-2 (a) Evaluation. Findings will be reviewed and corrected through the QA process. By what date will the systemic changes be completed? Compliance date: May 31, 2011</p>		

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	<p>Director, on 4/19/11 at 8:45 A.M., she indicated no preadmission assessment could be located.</p> <p>The Residence Director provided the facility policy and procedure for Initial Nursing Assessments/Evaluations, dated 01/2004, on 4/18/11 at 1:10 P.M. The policy indicated "Each resident must have an initial nursing assessment/evaluation completed by the nurse within seven days of his/her move in date...The initial assessment should verify at a minimum: That no acute or unstable chronic health condition exists which indicates the need for extended hospitalization or a stay in a long-term care facility until the condition stabilizes, medications required, functional abilities, mental and behavioral status, needed nursing treatments/tasks, safety concerns i.e. fall prevention, oxygen use with smoking, etc., the appropriateness of medication self-administration..."</p>						

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R0217	<p>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:</p> <p>(1) The services offered to the individual resident shall be appropriate to the:</p> <p>(A) scope;</p> <p>(B) frequency;</p> <p>(C) need; and</p> <p>(D) preference;</p> <p>of the resident.</p> <p>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.</p> <p>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.</p> <p>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.</p> <p>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.</p> <p>Based on interview and record review, the facility failed to ensure the service plans were revised to include interventions for new behaviors, Resident #6 and #2, and ensure service plans were signed by there resident, Resident #5, for 3 of 7 residents reviewed for service plans in the sample of 8.</p>		R0217	<p>Citation#3R217410IAC 16.2-5-8.1(a)(1-4)Clinical RecordsWhat corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?No residents were found to be affectedHow the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be</p>		05/31/2011	

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	<p>Findings include:</p> <p>1. Resident # 6's clinical record was reviewed on 4/18/11 at 11:00 A.M. The billing date was 3/12/10 and the move date 5/21/10 The most recent service assessment/negotiated service plan, was dated 3/12/10. The service plan indicated the facility administered the residents medications, the resident had not fallen and no interventions were listed, the resident had difficulty recalling the day, date, time and where located, she did not wander or attempt to leave the facility, with no interventions listed on the service plan for those behaviors.</p> <p>Resident service notes indicated the resident attempted to exit the facility on 12/2/10 at 2 p.m., through the back door, was very upset, and returned to facility by staff members. On 12/10/10 at "7 P resident noted wandering exit seeking, has become agitated combative with staff and other residents...threw a ceramic vase at nurse..." On 12/11/10, the resident was admitted to the hospital and returned 12/13/11. Nurses notes indicated increased agitation on 2/4/11 9 p.m. "attempting to open other residents doors going into rooms when able, took items from others rooms, unable to redirect...." "2/6/11 9 p res increased agitation exit</p>		<p>taken?No other residents were found to be affected.What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?The Wellness Director and licensed staff were re-educated to our policy and procedure regarding documentation, Medication Administration Record, and change of condition. The Wellness Director will review incident reports, Medication Administration Record, and service notes for appropriate documentation as indicated within our policy and procedure.How will the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance program will be put into place?The Wellness Director and /or designee will perform a random weekly review of incident reports, Medication Administration Record, and service notes to ensure continued compliance with our policy and procedure. Findings will be reviewed and corrected through ourQA process.By what date will the systemic changes be completed?Compliance date: 5/31/2011</p>		

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	<p>seeking attempting to exit building and enter others rooms...one on one most of shift..." "2/8/11 10 15 no a.m. or p.m. Resident found on floor in apt lying supine..."</p> <p>During an interview on 4/19/11 at 9:30 a.m. the Health Facility Administrator, she indicated she had no other service assessment/negotiated service plan for this resident. The facility lacked any update of the service plan having been updated to include interventions for wandering, combative behaviors or falls.</p> <p>2. Resident #5's clinical record was reviewed on 4/18/11 at 9:30 a.m. The most recent service assessment/negotiated service plan was dated 9/12/10. The assessment had not been signed or dated by the resident.</p> <p>3. Resident #2's clinical record was reviewed on 4/18/11 at 11:30 A.M. The admission service assessment/negotiated service plan, dated 2/14/11, indicated the resident takes medications, was able to manage the medications on her own, had no memory problems, did not wander and was not agitated or anxious, and had no falls. The assessment indicated the resident was oriented and provided all of own care including administering her own</p>						

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	<p>medications and required no staff interventions.</p> <p>Resident service notes indicated:" 2/24/11 3:30 P.M. resident was wandering halls and was in another resident's room left that room and was bothering another resident who was walking in the hall..." "2/24/11 5:30 p.m., Back door alarm on resident trying to get out the door. agitated when staff attempted to bring resident in, after several minutes..." "3/14/11 9 p.m. res was wandering halls went into other resident room and knocking on other res doors. res was redirected by staff and res husband to room...." "4/3/11 445 resident states hip/leg hurts...fell Friday night...915 p.m. left hip fracture..."</p> <p>During interview with the Wellness Director on 4/18/11 at 10:30 A.M., she indicated the resident's family sat the medications up and her spouse made sure she took them, she (the resident) was not able to self administer.</p> <p>The facility lacked evidence of having updated the service plan to include interventions for wandering.</p>						

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R0349	<p>(a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:</p> <p>(1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized.</p> <p>Based on interview and record review, the facility failed to ensure a clinical record was completely documented to include a resident leaving the facility with a family member for a doctor appointment and then being admitted to the hospital, and the reasons for as needed hydrocodone (narcotic pain medication) and times given, for 2 of 7 residents reviewed for accuracy of clinical records in the sample of 8. Resident #8 and #5</p> <p>Findings include:</p> <p>1. Resident # 8 was identified by the Wellness Director on 4/18/11 at 9:30 a.m., as having transferred from the facility. Resident # 8 clinical record was reviewed on 4/18/11 at 10:30 A.M. The most recent progress note, indicated "2/19/11 1130 a.m. pt(patient) states, 'I feel ok since fall. No noted injuries. Range of Motion without difficulty.'" The clinical record lacked any documentation of the resident leaving the facility. During interview with the well ness director on</p>		R0349	<p>Citation#4R349410 IAC 16.2-5-8.1(a) (1-4)Clinical RecordsWhat corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?no residents were found to be affected.How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?No other residents were found to be affected.What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?The Wellness Director and licensed staff were re-educated to our policy and procedure regarding documentation, Medication Administration Record, and change of condition. The Wellness Director will review incident reports, Medication Administration record and service notes for appropriate documentation as indicated within our policy and procedure.How will the corrective action(s) will be monitored to ensure the deficient practice will nor recur,i.e., what</p>		05/31/2011	

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	<p>4/18/11 at 10:30 a.m. she indicated the communication book indicated for evening shift on 2/28/11 the resident was in the hospital for a blood transfusion. LPN (Licensed practical nurse) #1 on 4/18/11 at 10:45 A.M. indicated she could find no more documentation on when the resident left the facility.</p> <p>During interview with the Health Facility Administrator on 4/18/11 at 10:45 A.M., she indicated the resident had went out with a family member to a physician appointment. She indicated the family member returned ran into the facility and told staff the resident was being admitted to the hospital. She indicated she knew this had been written in the communication book.</p> <p>The facility lacked evidence of having documented the time the resident went out with the family member or what the family member had said when they had returned and took the facility she was being admitted to the hospital.</p> <p>2. Resident #5's clinical record was reviewed on 4/18/11 at 9:30 a.m. Current physicians orders, dated 11/4/10, included an order for "hydrocodone apap 5/500(narcotic pain medication) give one orally every 4 hours as needed pain."</p>			<p>quality assurance program will be put into place?The Wellness Director and/or designee will perform a random weekly review of incident reports, Medication administration Record, and Service notes to ensure continued compliance with our policy and procedure. Findings will be reviewed and corrected through our QA process. By what date will the systemic changes be completed?Compliance date: May31,2011</p>			

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	<p>The narcotic sign out form indicated for march 2011 Hydrocodone was given at the following times: 3/1/11 at 7 P.M., 3/2/11 7:30 p.m., 3/3/11 7 p.m., 3/5/11 10 A.M., 3/7/11 7 P.M. 3/12/11 7:30 p.m., 3/16/11 at 8 P.M. and 3/25/11 7 P.M.</p> <p>The March 2011 medication administration record indicated Hydrocodone was given 3/1/11 at 7:30 p.m. for ankle pain and was effective, 3/11/11 at 7 P.M. for legs hurting and was effective and on 3/16/11 at 8:P.M. for feet hurting and was effective. The March MAR did not document any other doses of hydrocodone given. The resident service notes lacked documentation of Hydrocodone having been given in March 2011.</p> <p>3. The policy and procedure for Documentation, dated 1/2004, provided by the Administrator, on 4/18/11 at 1:00 p.m. indicated: "Resident service notes-...it is essential that staff document observations and occurrences accurately and as soon as possible after they occur...staff document only non routine observations and occurrences...Medications-document all medications on the medication assistance record...document prn (as needed) medications in the Resident Service Notes."</p>						

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R0410	<p>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.</p> <p>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.</p> <p>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.</p> <p>Based on interview and record review, the facility failed to ensure Mantoux testing for 1 of 8 residents prior to and/or on admission, Resident # 4, in a sample of 8.</p> <p>Findings include:</p> <p>The clinical record for Resident # 4 was reviewed on 4/18/11 at 10:20 A.M. The record indicated Resident # 4 moved in to the Residence 8/27/10. The September 2010 Medication Administration Record indicated Resident # 4 received the 1st</p>	R0410	<p>Citation #5 R410 410IAC 16.2-5-12(e) (f) (g) Infection Control What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice? No residents were found to be affected. Resident #4 had a Mantoux skin test administered by a licensed nurse with no evidence of tuberculosis. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? No other</p>	05/31/2011	

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	<p>step Mantoux on 9/7/10.</p> <p>In an interview with the Residence Director, on 4/19/11 at 8:45 A.M., she indicated she was not able to locate any documentation of a Mantoux test for Resident # 4 prior to or on admission to the facility.</p> <p>The Residence Director provided the facility policy and procedure for Mantoux Testing, dated 01/2004, on 4/18/11 at 1:10 P.M. The policy indicated "...it is best to administer, read, and record the result of the first Mantoux test before the resident moves in to the residence..."</p>		<p>residents were found to be affected. What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur? The Wellness Director and licensed staff were re-educated to our policy and procedure regarding Mantoux skin testing and Indiana state ruling 410IAC 16.2-5-12(e) (f) (g) Infection Control. How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Wellness Director and/ or Designee will perform a random monthly review of residents to ensure continued compliance with our policy and procedure regarding Mantoux skin testing and Indiana State ruling 410IAC 16.2-5-12(e) (f) (g) Infection Control. The Wellness Director implemented a tickler file of resident Mantoux skin test to be reviewed monthly to ensure continued compliance. Findings will be reviewed on an ongoing basis and corrected through our QA process By what date will the systemic changes be complete? Compliance Date 5/31/2011</p>		